



THE FLORIDA STATE UNIVERSITY
CENTER FOR ACADEMIC RETENTION & ENHANCEMENT

April 26, 2021

Dear Parents/Guardians:

The College Reach-Out Program (CROP) at Florida State University CARE is accepting applications for the Pre-College Summer Academy. This program will offer a **residential camp and day camp for students currently in grades 6 - 11.**

While at camp, students will take academic courses to prepare them for the next academic year and participate in enrichment activities throughout the summer. Students will be connected to FSU staff and mentors that will help them prepare for searching for, applying to, and succeeding in college. At the conclusion of the on-campus component, students will participate in an out-of-town trip where they will tour various colleges and universities, visit historic sites, eat in local restaurants, and participate in a range of cultural activities.

Students must meet both academic and financial qualifications (see below):

Academic Qualifications:

Students must either:

- 1) Be a potential first-generation student (neither parent can have finished a 4-year degree from a college);
- 2) Have a C or D in English, science, social studies, or math;
- 3) Have a GPA lower than 2.5 OR;
- 4) Have an achievement level below a Level 3 in English Language Arts (ELA) and mathematics, on the Florida Standards Assessments (FSA), or on the Algebra I End-of-Course

Financial Qualifications:

Parents/guardians must either:

- 1) Be eligible for free or reduced lunch;
- 2) Receive public assistance OR;
- 3) Be placed in foster care

The summer program and ALL activities are 100% FREE.

If you are interested in your child participating in the FSU CROP Summer Academy, contact Mrs. Inika Williams at williamsi@fsu.edu or 850-597-6615.

**PLEASE SCAN & EMAIL THE COMPLETED APPLICATION TO WILLIAMS@FSU.EDU.
The priority application deadline is Friday, May 21, 2021.**

Sincerely,

Mrs. Inika Williams, Ed.S

Upward Bound & College Reach-Out Program Director
Center for Academic Retention & Enhancement (CARE)



**Florida State University-CARE
Pre-Collegiate Programs
Parental Consent Form**

Student Name: _____

School Name: _____

I am applying for the:

_____ Residential **Middle School** Program
June 20- June 26, 2021

_____ Day Program for **Middle School**
July 5 – July 9

_____ Residential **High School** Program
June 27- July 9, 2021
For rising 11th and 12th graders

_____ Day Program for **High School**
July 12 - July 23, 2021
For Rising 9th and 10th graders



Florida State University 2021 Pre-Collegiate Summer Academy



Student Data

Student Name: _____ Birthdate: _____

Last Name
First Name
Middle Initial
Month / Day / Year

Mailing Address: _____
Street Address (where you receive mail)

City, State Zip Code

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

Academic Information

Current Grade: _____ Cumulative GPA: _____

2021-2022 Planned Courses

English: _____ Math: _____
 Science: _____ History: _____
 Foreign Language: _____

Career Interest: _____

College Choices: _____

Summer Academy

What type of fitness/wellness activities (i.e. Zumba, Jogging, Volleyball, Basketball, etc.) would you like CROP to provide during the summer program? _____

What social activities would you like to see provided during the summer program? _____

This summer will consist of many activities that will serve to assist you in your personal, social and academic development. What are some areas that you would like to see this summer? (i.e. self-efficacy, hygiene, math skills) _____

Academics, Attendance, Appreciation, Accountability and Attitude

The following essay should be typed, double spaced, Times New Roman 12 font, and contain no less than 300 - 500 words.

- Colleges/Universities, Majors and Careers of interest (explain why choice of colleges and major/career).
- How can the College Reach-Out Program (CROP) assist you in middle school or high school and college success? Also, what contributions can you make to enhance the program?

Student Signature: _____

Date: _____

Parent Signature: _____

Date: _____

Office Use Only:

Accepted Denied Wait Listed Date: _____ Staff' Initials: _____



Florida State University

2020-2021 CARE College Reach-Out Program Application

Parent/Guardian Data

Mother's Name: _____

Email: _____

Best Contact Number: _____

Do you live with this parent? Yes No

Highest Education Level:

- No High School Diploma High School Diploma/GED
 Associate's Degree Bachelor's Degree Master's Degree
 Doctorate/Professional Degree

Father's Name: _____

Email: _____

Best Contact Number: _____

Do you live with this parent? Yes No

Highest Education Level:

- No High School Diploma High School Diploma/GED
 Associate's Degree Bachelor's Degree Master's Degree
 Doctorate/Professional Degree

Confidential Financial Information

Required

Family Annual Income (before taxes): \$_____ Total # of family members in household (incl. student):_____

Single Parent Household: Yes or No

Does your family receive assistance from any of the following sources? Yes No

- _____ Temporary Aid to Needy Families (TANF) _____ Social Security
_____ Food Stamps _____ Retirement Benefits
_____ Veterans Benefits _____ Other: _____
_____ Free/Reduced lunch

Attach proof for eligibility verification

Parent/Guardian Agreement

I hereby certify that all information provided in this application to the CARE College Reach-Out Program is complete, correct, and true to the best of my knowledge...

I hereby authorize the school that my child attends to release the following information to FSU CARE staff: a) Report Cards, b) Official Transcripts, c) Test Scores, d) Progress Reports, and e) Behavioral Referral Reports...

I agree to fully support and encourage my child in his/her efforts to complete high school, attend college, and obtain a college degree. I will also attend meetings and other events as requested by the program...

I hereby consent, declare and represent, as evidenced by my signature below, that I am on notice that Florida State University has no medical, health, or hospitalization insurance to cover my minor child in the event of accident, injury, illness, or death...

Parent Signature: _____

Date: _____



Florida State University Immunization Form Instructions

Use the instructions on this page as a guide to complete the Immunization Form.

Section 1:

List any relevant personal and family medical history, and any known allergies, including medications.

Section 2:

If you are under 18, this Section is required to be signed by your parent or guardian to allow us to administer medical treatment if necessary.

Section 3:

This section should be completed by your healthcare provider's office. Measles, Mumps, Rubella (MMR) is a required immunization for students born on or after January 1, 1957.

You must provide proof of two combined MMR (measles {rubeola}, mumps, rubella) immunizations.

The first MMR must have been given on or after January 1, 1968 and on or after the first birthday.

The second MMR immunization must have been given 28 days or more after the first MMR.

Section 4:

This section should be completed by your healthcare provider's office. Hepatitis B is a recommended but not required immunization. You may choose to opt out of this series by completing Section 6.

Section 5:

This section should be completed by your healthcare provider's office. Meningitis is a recommended but not required immunization. You may choose to opt out of this series by completing Section 6.

Section 6:

This is where you may elect to opt out of the Hepatitis B and/or the Meningococcal Meningitis immunization series as referenced in the instructions for Sections 4 and 5 above. Section 6 requires you to mark the box next to the immunization(s) you wish to opt out of and to sign and date. Note that failure to sign and date your decision to opt out of the Hepatitis B and/or Meningitis vaccines will prevent us from processing this form and a hold will remain on your student account.

Section 7:

This section should be completed by your healthcare provider's office if you have received the Meningitis B immunization series. **(This is not a required immunization.)**

Section 8:

This section should be completed by your healthcare provider's office if you have received the Tetanus-Diphtheria and Pertussis (Tdap) immunization. **(This is not a required immunization.)**

Section 9:

This section should be completed by your healthcare provider's office if you have received the Tetanus-Diphtheria (TD) immunization. **(This is not a required immunization unless you are an NCAA Athlete.)**

Section 10:

This section is the Authorization that the information on the form is accurate. This Section must be completed by your healthcare provider's office, and must be signed, dated and must have an official office stamp.

Once completed: You may submit this form to the Health Compliance Office in one of the following ways:

Email: healthcompliance@fsu.edu Please be aware that email sent over the Internet is not considered secure. FSU shall not be liable for any breach of confidentiality resulting from this form of communication.

Fax: 850-644-8958

Mail: 960 Learning Way, Tallahassee, FL 32306-4178

FSU Dropbox: <https://dropbox.fsu.edu>

In Person: You may also drop off your forms In Person to the Health Compliance office at UHS during regular business hours <http://uhs.fsu.edu/about/contact-us> at 960 Learning Way.

Unless otherwise indicated, University Health Services recommends students receive the optional immunizations listed above. To schedule an appointment, please call 850-644-4567.



FLORIDA STATE UNIVERSITY
Immunization Form



Part A- Print or type. Illegible form will not be processed

LAST NAME: _____ FIRST NAME: _____ DOB: _____

EMPLID _____ EMAIL _____ PRIMARY PHONE# _____

Please list any relevant personal and family medical history: _____

1. Do you have any allergies (including Medications): No Yes Please list if yes: _____

REQUIRED AUTHORIZATIONS FOR CARE FOR STUDENTS UNDER THE AGE OF 18: I authorize health center personnel to provide medical and surgical care including examinations, treatment, immunizations and the like for my son/daughter. In the event of serious disease or injury, I understand that all reasonable efforts will be made to contact me but failure to contact will not prevent emergency treatment if necessary to preserve life or health.

Signature: _____ Date: _____

3. Measles, Mumps, Rubella (Required) 2 doses of vaccine OR a blood test showing immunity	Dose 1 _____ MM/DD/YR	Dose 2 _____ MM/DD/YR
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4. *Hepatitis B (Required or Complete Section 6) 3 doses of vaccine OR a blood test showing immunity	Dose 1 _____ MM/DD/YR	Dose 2 _____ MM/DD/YR	Dose 3 _____ MM/DD/YR
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5. *Meningococcal Meningitis Serogroups (Required or Complete Section 6) 1 dose since age 16. (such as Menactra, Mencevax, Menomune, MCV4, Menveo, and ACYW-135)	Dose 1 _____ MM/DD/YR	Dose 2 _____ MM/DD/YR
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*Waiver information: I have received the required information regarding the risk of acquiring Meningococcal Meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations by checking the boxes and signing below. I understand that I may decline either or both immunizations and that declining these vaccines now does not mean I may not receive them in the future.

Meningitis Waiver Hepatitis B Waiver Patient Signature: _____ Date: _____

Meningitis B (Optional) Please circle type of vaccine (Bexsero or Trumenba)

7. Meningitis B Dose 1 _____ MM/DD/YR	Meningitis B Dose 2 _____ MM/DD/YR	Meningitis B Dose 3 _____ MM/DD/YR
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8. Tetanus-Diphtheria and Pertussis (Tdap) (Optional) (Required for NCAA Athletes) Incoming students should have one Tdap booster at 11 years of age or older.	Tdap _____ MM/DD/YR
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9. Tetanus-Diphtheria (Td) (Optional)	Td _____ MM/DD/YR
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This section to be completed by your healthcare provider

Authorization and additional comments:
The immunizations dates and any statement of contraindications to immunizations entered on this document are, as of the date signed, verified by my signature below. Additional comments: _____

10. _____
Clinician OR Records Custodian Name

Clinician OR Records Custodian Signature

DATE

OFFICE STAMP

Once Completed: You may submit this form to the Health Compliance Office in one of the following ways:
Email: healthcompliance@fsu.edu Please be aware that email sent over the Internet is not considered secure. FSU shall not liable for any breach of confidentiality resulting from this form of communication.

Fax: 850-644-8958

Mail: 960 Learning Way, Tallahassee, FL 32306-4178

FSU Dropbox: <https://dropbox.fsu.edu>

In person: You may also drop off your forms in person to the Health Compliance office at UHS during regular business hours <http://uhs.fsu.edu/about/contact-us> at 960 Learning Way.



Medical/Liability Questionnaire

The Florida State University-CARE Pre-Collegiate Programs

Program Event: 2021 Summer Academy

Does your child take any prescription medications that will need to be continued during the CARE Pre-Collegiate Summer Academy?

- Yes. If yes, complete PART I**
 No. If no, complete PART II

PART I (For students taking prescription medications):

If your child takes prescription medications that will be needed during the program, please have your child's health care practitioner (prescribing doctor) complete PART I and sign. **THIS IS NOT A REQUEST FOR A PHYSICAL EXAM.** Simply ask your practitioner to fill out and sign. Parents should sign in the area noted below as well

Health Care Practitioner (Doctor) Section Only:

Prescription Medications: Name of Student (Patient): _____ uses the following prescription medications

Medication	Dosage	Purpose

Medications available in the program first aid kits (please circle Y for all medications okay to dispense):

- | | | |
|---|---|---|
| Y | N | Tylenol |
| Y | N | Dramamine |
| Y | N | Ibuprofen |
| Y | N | NyQuil/DayQuil |
| Y | N | Tums or other antacid |
| Y | N | Benadryl or other antihistamine tablets |
| Y | N | Sunscreen 30 SBF or higher |
| Y | N | Muscle pain cream (like Icy Hot, etc.) |

I, _____ (name of practitioner), have reviewed this patient's medications and certify that the information is correct and that the patient is physically and emotionally able to self-administer these medications without adult supervision during 2021 Summer Academy. In addition, I have reviewed the list of over-the-counter medications for potential interactions with the patient's prescription regimen and approve their use when administered by an adult staff member according to package directions.

Signature of Practitioner

Practice Phone

Date

I, _____ (print parent/guardian name) agree that my child can self-administer their own prescription medications as indicated above by the health care practitioner.

Parent/Guardian Signature

Date

PART II: Over the Counter (first-aid type) medications
(Section for students NOT taking prescription medications).

Parents: Review the list and circle 'Y' for yes or 'N' for no next to medications that you want or do not want given to your child in case of minor illness or injury.

- | | | |
|---|---|---|
| Y | N | Tylenol |
| Y | N | Dramamine |
| Y | N | Ibuprofen |
| Y | N | NyQuil/DayQuil |
| Y | N | Tums or other antacid |
| Y | N | Benadryl or other antihistamine tablets |
| Y | N | Sunscreen 30 SBF or higher |
| Y | N | Muscle pain cream (like Icy Hot, etc.) |

I, _____ (print parent/guardian name) give The Florida State University-CARE/CROP/UB staff permission to administer the items circled "Yes" above while my child participates in The Florida State University-CARE Pre-Collegiate 2021 Summer Academy.

Parent/Guardian Signature

Date



Florida State University-CARE
Pre-Collegiate Programs

MEDICATION CONSENT FORM

If your student will be taking prescription medication, please fill out the following information and return it to your Advisor. All medication should be in an original marked container including student name, medication name, and dispensing directions and should be given directly to your advisor prior to departure.

Name of Student _____

Name of Medication(s) _____

Time of Dose(s) _____

Any reactions _____

I give consent for the FSU-CARE Pre-Collegiate Staff to dispense the above medication as directed.

Name of Parent/Guardian _____

Date _____

NAME OF STUDENT _____

FSU-CARE Pre-Collegiate Programs will supply to students, on an as needed basis only, the following medications: Benadryl, Tylenol, Advil, Pepto-Bismol, Dramamine, & Imodium.

I give consent for the FSU-CARE Pre-Collegiate Staff to dispense the above listed medications as needed.

OR

I do not give consent for the FSU-CARE Pre-Collegiate Staff to dispense any medications.

Name of Parent/Guardian _____

Date _____



Florida State University-CARE
Pre-Collegiate Programs
Parental Consent Form



(Print camper's complete legal name)

(School Student Number)

A. I _____ approve my child's participation in
(Parent/Guardian, print your name)

the 2021 Summer Academy affiliated with Florida State University CARE CROP/UB program. I understand that in order for my child to participate in the camp, I must provide a copy of proof of medical insurance to accompany the camp registration form.

Please list any medical conditions and current medications (prescription and non-prescription) that we should be aware of:

Blank lines for listing medical conditions and medications.

If the program staff determines that a student's activities while attending the camp are contrary to the general operational, safety and health policies of the University, the parent or guardian agrees to pick up their child from camp.

Emergency Medical Authority

B) In the event that we are unable to contact you, please indicate a secondary contact with authority to initiate medical treatment. Be sure to include a phone number:

Blank lines for secondary contact information.

C) In the event that we are unable to contact either you or the emergency contact,

I, _____ authorize the Program Staff to use their
(Parent/Guardian, print your name)

discretion in initiating medical treatment.

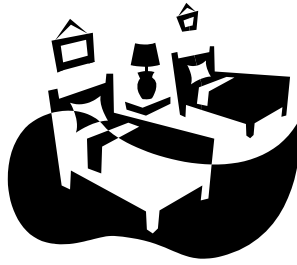
Parent's/Guardian's Signature

Date

(Address-Street)

(Home Phone)

(Other Phone)



**2021 FSU-CROP PRE-COLLEGIATE PROGRAMS'
SUMMER ACADEMY
FOR RESIDENTIAL APPLICANTS ONLY**

ROOMMATE PREFERENCE FORM

Please list the name of 3 student that you would prefer to room with and the name of 1 alternate student in the event that your first choice is not available. Select two people you would like to have as suitemates. We cannot guarantee that you will be with the roommate of your choice, but we will do our best.

Roommate Choice

1) _____
(TOP CHOICE)

2) _____
(ALTERNATE)

3) _____
(ALTERNATE)

4) _____
(ALTERNATE)

Your Name: _____

**FLORIDA STATE UNIVERSITY CARE
PRE-COLLEGIATE PROGRAMS
2021 SUMMER ACADEMY**

STATEMENT OF VOLUNTARY CONSENT AND WAIVER

Participant's Name _____

NOTICE TO THE MINOR CHILD'S NATURAL GUARDIAN
READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF THE FSU BOARD OF TRUSTEES OR ITS AGENTS ("FSU") USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM FSU IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND FSU HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

I. CONSENT FOR PARTICIPATION AND WAIVER OF LIABILITY

I _____ (print parent/guardian name), having been fully informed of the CARE Pre-Collegiate Programs' Summer Academy's tutorials/activities, hereby voluntarily and freely consent to my child's participation in the CARE Pre-Collegiate Programs' Summer Academy. I understand the CARE Pre-Collegiate Programs' Summer Academy includes my child's participation in activities including, but not limited to walking, running, swimming, and being transported locally to field trips in and around Tallahassee, as well as other cities in the state of Florida.

In consideration of my child's participation and for other good and valuable consideration, receipt of which is hereby acknowledged, I, individually and on behalf of my child, expressly assume all risks of injury, accident, property damage and loss arising from or in any way associated with my child's participation in the CARE Pre-Collegiate Programs' Summer Academy.

I have actual knowledge, and am fully conscious, of the particular and inherent dangers associated with my child's transportation to and from the Summer Academy and participation in the CARE Pre-Collegiate Programs' Summer Academy. Having this knowledge, I, myself and on behalf of my child, hereby and forever, release, waive, discharge, and hold harmless, the CARE Pre-Collegiate Programs' instructors, coaches, mentors, the

Center for Academic Retention and Enhancement, The Florida State University, the Florida Board of Trustees, and their employees and agents, from any and all suits, liability, claims and/or loss, whether caused by negligence or otherwise, arising from or associated with my child's participation in the CARE Pre-Collegiate Programs' Summer Academy. I understand this waiver includes any suits, liability, claims, or demands based on negligence, action, or inaction on the part of the CARE Pre-Collegiate Programs' instructors, coaches, mentors, the Center for Academic, Retention and Enhancement, The Florida State University, and the Board of Trustees and/or any of their agents or employees.

II. CONSENT FOR MEDICAL TREATMENT AND WAIVER OF LIABILITY

I hereby declare and represent that I am aware that Tallahassee Memorial Healthcare or The Florida State University Health & Wellness Center will be utilized if necessary for the treatment of certain injuries and illnesses that might arise out of the CARE Pre-Collegiate Programs' Summer Academy activities. I hereby consent to such treatment. I understand the treatment may involve administration of medication and/or drugs. I do understand that, generally, the administration of proper medication or drugs is preferable to leaving the condition untreated and that violent reaction to the medication or drugs could occur. The following are the drugs or medications that disagree with my child or to which he/she is sensitive or allergic:

(Leaving this space blank means NONE)

Further, my child has the following chronic diseases (e.g., asthma, epilepsy, congenital defects, etc.)

(Leaving this space blank means NONE)

Should routine first aid or medical needs arise such as cuts scrapes, bruises, or lacerations, I consent to treatment necessary to prevent infection and to promote healing (e.g. cleansing and administration of antibiotics) as appropriate under the circumstances.

If a major medical emergency or medical trauma occurs, I understand Tallahassee Memorial Healthcare and/or the Florida State University's Health & Wellness Center professional staff will provide whatever care or treatment reasonable under the circumstances and will refer my child, as soon as practicable, to the appropriate physician/facility for further treatment. Should Tallahassee Memorial Healthcare and/or the Florida State University's Health & Wellness Center be unable to contact me, it is my desire my child receive such treatment, nonetheless.

Having full knowledge and appreciation of all risks associated with the medical treatment and referral of my child in case of injury or illness, as set forth in Section II of this document, I, myself and on behalf of my child, hereby and forever, release, waive, discharge, and hold harmless the CARE Pre-Collegiate Programs, the Center for Academic Retention and Enhancement, The Florida State University, the Florida Board of Trustees and their employees and agents, from any and all suits, liability, claims and/or loss, whether caused by negligence or otherwise, arising from or associated with the treatment or referral of my child to the appropriate health care provider. I understand this waiver includes any suits, liability, claims, or demands based on negligence, action, or inaction on the part of the CARE Pre-Collegiate Programs, the Center for Academic Retention and Enhancement, The Florida State University and the Board of Trustees and/or any of their agents or employees.

THEREFORE, I do hereby declare and represent that in making, executing, and tendering this statement of voluntary consent and waiver:

(a) I understand the CARE Pre-Collegiate Programs Summer Academy, the general schedule of activities of the CARE Pre-Collegiate Programs' Summer Academy, and the dangers and risks inherent in participating in the

CARE Pre-Collegiate Programs' Summer Academy and its activities,

(b) I have read this statement and understand its contents,

(c) I have had the opportunity to ask any questions I may have regarding my child's participation in the CARE Pre-Collegiate Programs' Summer Academy,

(d) I have executed it of my own free will and choice, with the intent to allow my child's full participation in the CARE Pre-Collegiate Programs Summer Academy and for his/her benefit, and

(e) I am 18 years of age or older and am legally competent to execute this document.

Parent Signature

Home Phone Number

Work Phone Number ext.

Emergency Contact Phone Number